(a) A composite of rates of potentially preventable hospital admissions for heart failure, chronic obstructive pulmonary disease, and diabetes. The rate of potentially preventable hospital admissions for diabetes is a composite measure of uncontrolled diabetes, short term diabetes complications, long term diabetes complications and lower extremity amputation for diabetes.

(b) A composite of rates of potentially preventable hospital admissions for dehydration, urinary tract infections, and bacterial pneumonia.

(c) Rates of an all-cause hospital readmissions measure.

§ 414.1235 Cost measures.

Costs for groups of physicians subject to the value-based payment modifier are assessed based on the following 6 cost measures:

(a) Total per capita costs for all attributed beneficiaries; and

(b) Total per capita costs for all attributed beneficiaries with diabetes, coronary artery disease, chronic obstructive pulmonary disease, or heart failure.

(c) Total per capita costs include all fee-for-service payments made under Medicare Part A and Part B.

(1) Payments under Medicare Part A and Part B will be adjusted using CMS' payment standardization methodology to ensure fair comparisons across geographic areas.

(2) The CMS–HCC model (and adjustments for ESRD status) is used to adjust standardized payments for each cost measure; that is—

(i) Total per capita costs; and

(ii) Total per capita costs for beneficiaries with the following conditions: coronary artery disease, COPD, diabetes, and heart failure.

§ 414.1240 Attribution for quality of care and cost measures.

Beneficiaries are attributed to groups of physicians subject to the value-based payment modifier using a method generally consistent with the method of assignment of beneficiaries under § 425.402 of this chapter.

§ 414.1245 Scoring methods for the value-based payment modifier using the quality-tiering approach.

For each quality of care and cost measure, a standardized score is calculated for each group of physicians subject to the value-based payment modifier by dividing—

(a) The difference between their performance rate and the benchmark, by

(b) The measure's standard deviation.

§ 414.1250 Benchmarks for quality of care measures.

(a) The benchmark for quality of care measures reported through the PQRS using the claims, registries, EHR, or web interface is the national mean for that measure's performance rate (regardless of the reporting mechanism) during the year prior to the performance period. In calculating the national benchmark, individuals' and groups of physicians' performance rates are weighted by the number of beneficiaries used to calculate the individuals' or group of physician's performance rate.

(b) The benchmark for each quality of care measure reported through the PQRS using the administrative claims option is the national mean for that measure's performance rate during the year prior to the performance period.

§ 414.1255 Benchmarks for cost measures.

The benchmark for each cost measure is the national mean of the performance rates calculated among all groups of physicians for which beneficiaries are attributed to the group of physicians and are subject to the value-based payment modifier. In calculating the national benchmark, groups of physicians' performance rates are weighted by the number of beneficiaries used to calculate the group of physician's performance rate.

§ 414.1260 Composite scores.

(a)(1) The standardized score for each quality of care measure is classified into one of the following equally weighted domains to determine the quality composite:

(i) Patient safety.

(ii) Patient experience.

(iii) Care coordination.